Department of HUMAN SERVICES

Ground Emergency Medical Transportation (GEMT) Payment Program

May 7, 2019

GEMT Payment Program

- The Iowa Legislature passed House File (HF) 2285 during the 2018 session
- Authorized the GEMT Payment Program
- This is a voluntary Intergovernmental Transfer (IGT) based program
- Provides additional payments to Emergency Medical Service (EMS) providers

GEMT Payment Program

- The State Plan Amendment is currently being reviewed by the Centers for Medicare and Medicaid Services (CMS)
- Also submitted a 42 CFR §438.6(c) pre-print to implement within Medicaid managed care

Intergovernmental Transfer

- IGTs are transfers of funds from another government entity (e.g. county, city, or another state agency) to the state Medicaid agency
- Provides the funding of the state share of payments
- Requires an executed IGT agreement
- Managed care required use of IGTs

Program Eligibility

- A provider that meets all of the following requirements continuously during the State Fiscal Year (SFY):
  - Provides GEMT services to Iowa Medicaid enrollees.
  - Enrolled as an Iowa Medicaid provider for the period being claimed.

Program Eligibility

– Is owned or operated by an eligible governmental entity, to include the state, a city, county, fire protection district, community services district, health care district, federally recognized Indian tribe or any unit of government as defined in 42 C.F.R. Sec. 433.50.

Annual Provider Requirements

- Providers must:
  - Complete and submit the CMS-approved GEMT cost report
  - Complete and sign the IGT agreement between the Iowa Department of Human Services (DHS) and the eligible governmental entity

Cost Reporting Process

- Enrolled GEMT provider downloads the current version of the CMS-approved GEMT cost report (*not yet available*)
- Cost reports are completed for costs incurred during the SFY
- SFY is July 1, through June 30

Cost Reporting Process

- Submit to costaudit@dhs.state.ia.us
- Iowa Medicaid Enterprise (IME) reviews the cost report for completeness and completes the desk review within 90 business days of receipt
- If cost report not complete, the provider must make necessary corrections and resubmit the cost report

Cost Report and Date Examples

- Cost report used to set GEMT prospective payment rates for upcoming SFY
- Example, SFY 2019 cost report will establish July 1, 2020 prospective payment rates

Prospective Payment Rate

- Prospective payment rate is calculated as follows:

Formula:

1. Actual allowable direct and indirect costs – Medicaid payments for mileage and base rate = Uncompensated Care Cost
2. Amount in (1) ÷ Total number of transports = Uncompensated average cost per transport

Billing and Claims

- Providers will submit claims as they currently do
- Only difference will be an additional line item entry for A0999
- A0999 will be set to pay the provider-specific uncompensated average cost per transport for the current SFY

Billing and Claims

- Example claim submission:
  - A0425 – Mileage
  - A0429 – Transport (use appropriate code for BLS or ALS)
  - A0999 – Provider-specific average uncompensated cost per transport amount from cost report

Billing and Claims

- GEMT Payment Program is conducted in such a way that it doesn't result in any additional expenditures from the state general fund:
  - Payments are not considered to be an individual increase to current fee-for-service rates
  - Payments are based on the actual costs to perform EMS transports

Billing and Claims

- IME uses the base year cost report to determine the uncompensated average cost per transport
- Claim payment example:
  - A0425 - $52.20 ($2.61 * 20 miles)
  - A0429 - $114.30
  - A0999 - $1,300.00
  - Total Claim Payment - **$1,466.50**

Approximate Rate Timing

- 6/30 – End of SFY
- 11/30 – Cost report due to IME
- 3/31 – Prospective payment rates calculated, provider notification and prospective payment rate sent to the Managed Care Organizations (MCOs)
- 7/1 – Prospective payment rates effective date

Program Startup

- Cost reporting process to begin the program
  - SFY 2018 and SFY 2019 cost reports will be due at the same time
  - The SFY 2018 cost report will be used to set the July 1, 2019 prospective payment rate
  - The SFY 2019 cost report will be used to set the July 1, 2020 prospective payment rate

Program Startup

- Initial prospective payments will be made at the estimated uncompensated care average cost per visit used in the public/tribal notice
- Provider-specific rates for SFY 2019 will be effective 60 days after review of the SFY 2018 cost report

Program Startup

- After July 1, 2019, an adjustment to the July 1, 2020 rate will be included for prior year overpayment or underpayment that may have occurred.
- This adjustment will only be required for the first year.

Questions?